Evaluation of Transition to Recovery (TRec) Program

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1 Background

1.1 Recovery-orientated mental health services and the establishment of TRec

Recovery-oriented approaches are increasingly being used to improve mental health services in Australia [1-4] and around the world. These approaches have been developed as alternatives to traditional clinical models of service, which focus primarily on alleviation of symptoms.

The Australian Government defines personal recovery as "being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues" p. 11 [1]. A range of models have been applied to the concept of recovery. A recent formal review of these conceptual models and recovery themes identified five key areas of the recovery process: establishing social connectedness; hope and optimism; positive self-identify; quality and meaning in life; and personal empowerment/control/ responsibility [5].

Woden Community Services (WCS) identified the need for a recovery-oriented program in Canberra that would support people with a mental illness, at times of transition and potential vulnerability, and reduce the risk of hospital [re]admission. Accordingly, in 2011, with funding from Mental Health ACT (MH ACT), WCS established *The Transition to Recovery* (TRec) program, an intensive 'step up, step down' community outreach service.

The TRec program provides support to service users for up to 12 weeks. It works with people with a mental illness, to support their recovery and independence following discharge from hospital (step down), or to provide additional support in the community to assist individuals with a mental illness to manage sub-acute symptoms to prevent hospitalisation (step up).

1.2 The evaluation of TRec

A formal evaluation of the TRec program was commissioned to examine its effectiveness and acceptability and to identify whether modifications were needed to improve the program. The Australian National University's National Institute for Mental Health Research (NIMHR) was commissioned to undertake this evaluation by the WCS.

The evaluation was designed and supervised by Prof Kathy Griffiths, NIMHR Director and managed by Julia Reynolds (Clinical Psychologist, NIMHR). The day to day running of the research was undertaken by two Research Assistants. In addition to their academic research qualifications they had lived experience of mental illness. One had carer experience and one had consumer experience. The data analyses were undertaken by two Research Assistants who had particular expertise in quantitative and qualitative analysis techniques.

The following questions of interest were developed through a review of TRec's contracted objectives and discussion with stakeholders:

1. Is the TRec program effective: Does participation reduce the risk of relapse and (re-) admission to hospital?
2. Does participation in the TRec program support recovery by:
   a. Providing the right kind of support at times that participants require it?

b. Providing support to increase participants' awareness of and capacity to access community resources and support networks?
c. Providing support, education and opportunities to increase their knowledge, skills and confidence in managing future crisis and to develop personal resources to enhance their mental and emotional well-being?
d. Delivering the service in a manner that is acceptable to stakeholders and consistent with a recovery-oriented approach?

3. How can the program be improved?

This final report summarises key aspects of the quantitative and qualitative analyses conducted. Two cohorts of TRec participants were evaluated, and feedback from other stakeholder groups (such as TRec workers, ACT MH staff, and carers of TRec service users) was sought and analysed where available. For participants who provided their consent, detailed service use data were also obtained from MH ACT and analysed.

2 Method

2.1 Participants and Procedure

2.1.1 Participants engaged with the TRec program

The original evaluation design included three cohorts of participants: 1) the post-TRec cohort; 2) the Pre-TRec cohort; and 3) the Improved-program cohort.

1. *Post-TRec cohort*

The Post-TRec group (n= 20) consisted of those people who had already completed the program before the evaluation began. Each person was interviewed on one occasion after they had participated in the TRec program. Just over half were female (55%, n = 11). The average age was 41 years (SD = 8.7, Range = 32- 62 years).

2. *Pre-TRec cohort*

The Pre-TRec group (n=10) consisted of people who entered TRec during the period of the evaluation. This group was to be interviewed as they began the program and when they completed it. Unfortunately, these participants did not take up the opportunity to complete the Post-TRec interview.

However, some pre-post program data is available for the participants in the Pre-TRec group who provided consent for the evaluation team to access data about their service use and data from the outcome measures administered routinely by TRec and MH ACT staff.

Seven Pre-TRec participants were female (70%). The average age was 33.3 years (*SD* = 14.3, *Range* = 18- 61 years).

3. *Improved-program cohort*

The original design involved a third cohort. This group would have enabled the assessment of the impact of recommendations for program change made after feedback from the first two cohorts. Unfortunately, it was not possible to recruit sufficient participants to form this third cohort.

2.1.2 Characteristics of overall TRec participant sample

In total, 30 consumers agreed to participate in the TRec evaluation study including18 females (60%) and 12 males (40%). On average participants were 38.3 years old (*SD* = 11.3, *Min* = 18, *Max* = 62).

The TRec program provides Step Up support to assist people who are at risk of being admitted to hospital and Step Down support for people who are being discharged from hospital and could benefit from additional support to reduce the risk of relapse and re-admission. Approximately half of the participants reported being in the Step Up program (n = 16, 53.3%), two participants (6.7%) reported being in the Step Down program (n = 2, 6.7%) and 12 participants did not report whether they were in the Step Up or the Step Down program.

The majority of participants had completed five or six years of secondary school (n = 20, 66.7%), one participant (3.3%) reported completing four years of secondary school, two participants (6.7%) some secondary school and one participant (3.3%) had completed primary school only. A substantial

minority of participants had completed tertiary studies including Bachelor degrees (n = 8, 26.7%), undergraduate degrees (n=4, 13.3%), other certificates (n = 4, 13.3%), apprenticeship (n=1) and a higher degree (n=1).

Some participants (n =9, 30%) were in full or part-time work or working on a voluntary basis. Three participants (10%) were studying (full- or part-time). For a complete description of participants' activities, see Figure 1.

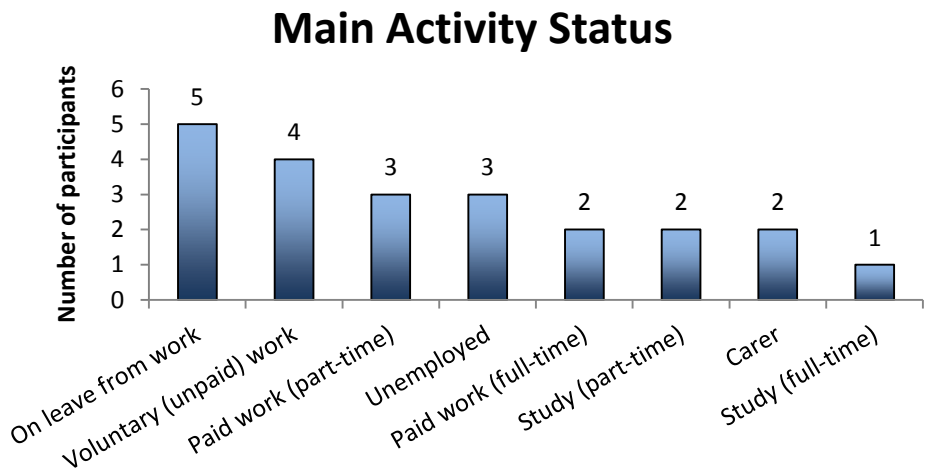

Figure 1. Number of participants by main activity status

During the interviews, 20 of the participants reported diagnostic information. The primary diagnosis most frequently reported by participants was schizophrenia (n = 8, 40%), followed by depression (n = 4, 20%) and bipolar disorder (n = 4, 20%). For further information about self-reported diagnoses, please see Figure 2.

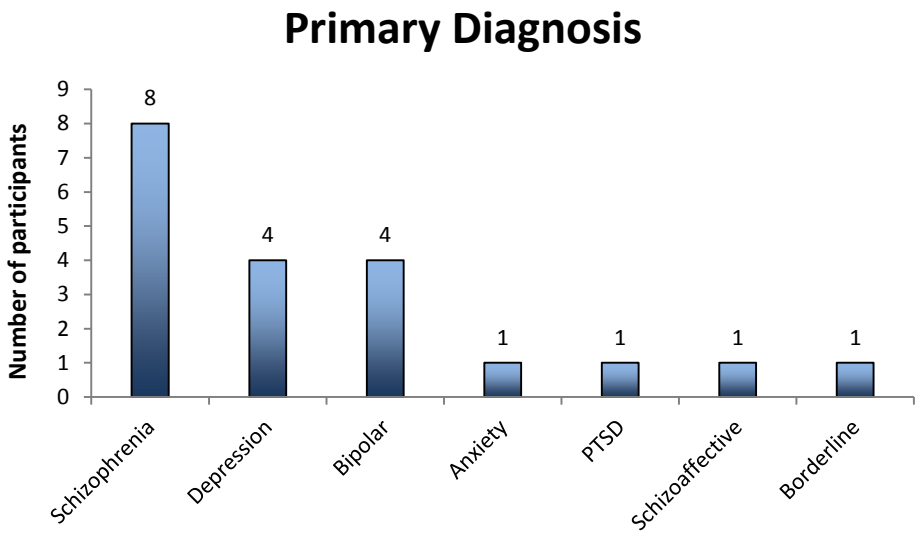

Figure 2. Number of participants by self-reported primary diagnosis

Diagnostic information was also obtained from MH ACT for those participants who had provided their consent for this information to be released to the evaluation team. For 12 participants, it was possible to obtain self-reported diagnoses and clinician-reported diagnoses. This diagnostic information was highly concordant with the self-reported data (92.3% agreement).

With respect to legal status, about half of the participants (n = 16, 53.3%) reported that they received treatment on a voluntary basis and two (6.7%) were the subject of psychiatric treatment orders (PTO). Twelve 12 participants (40%), did not report the legal status of their participation.

2.1.3 Carers

Unfortunately, it was possible to obtain data from only one carer. In order to protect this person's privacy, these data are not reported.

2.1.4 TRec and MH ACT Workers

TRec workers (n = 8) completed a self-report questionnaire and MH ACT Community Team staff (n = 14) provided additional written feedback.

2.2 Procedure

Data were collected in interviews conducted by people who had lived experience of mental illness.

These Interviews included formal questionnaires, structured interview questions and open questions. A literature review was undertaken to identify measures that had good psychometric properties and, where possible, had incorporated service user input and feedback during the development of the measures. Modifications to these measures were undertaken following feedback from key stakeholders including the interviewers, TRec and ACT Mental Health (ACT MH) staff as well as the TRec Consumer and Carer Advisory Group and an Expert Consumer and Carer Advisory group convened by the researchers to examine the measures under consideration. Questionnaires were administered either in written form or orally depending on the participant's preference. Measures incorporated in the formal questionnaire included the abbreviated Life Skills Profile (LSP-16); Kessler Psychological Distress Scale (K-10); Personal Well-Being Index; three subscales from the Self-stigma of Depression Scale (SSDS). In addition, TRec workers completed the Recovery Self-Assessment Scale (RSA). However, it was necessary to exclude some measures from the analysis due to insufficient data (see Appendix A).

For consenting participants, the evaluation team also accessed data about participant service use and data from the outcome measures administered routinely by MH ACT and TRec staff.

Participants in both cohorts were invited to nominate a carer to provide feedback on TRec. The carer was then invited to complete a brief questionnaire and to provide any additional feedback that they wished. The questionnaire was posted to the carer with a stamped self-addressed return envelope.

MHACT and TRec staff were invited to express their views through brief questionnaires. These were in printed format and distributed and collected by the respective team leaders.

3 Results

3.1 Effectiveness: does participation in the TRec program support recovery and reduce the risk of relapse and readmission to hospital?

In order to examine this question, data from questionnaires pertaining to life skills, psychological distress, quality of life and self-stigma were analysed and service use was examined.

3.1.1 Life Skills Profile (LSP-16)

The Life Skills Profile LSP-16 is designed to measure life skills associated with good functioning. ACT Mental Health Clinical Managers routinely administer the LSP-16. When participants enter and exit the program, TRec workers request the LSP-16 data from the Clinical Managers. If the Clinical Managers are unable to complete an LSP-16, the TRec worker completes it. The LSP-16 data were analysed to investigate whether participants' life skills improved over the period they participated in the TRec program.

In the current analyses, high scores indicate skill deficits. A two-tailed paired samples t test[1] was conducted to compare LSP-16 entry (M = 12.5, SD = 5.9) and exit (M = 5.9, SD = 2.8) scores for participants. There was a statistically significant mean difference between pre- and post-scores, t (26) = 7.12, p < .001, Cohen's d = 1.4 (large effect). **Participants improved on average by 6.6 points on the LSP-16 (SD = 4.8) after completing the program; see Figure 3.**

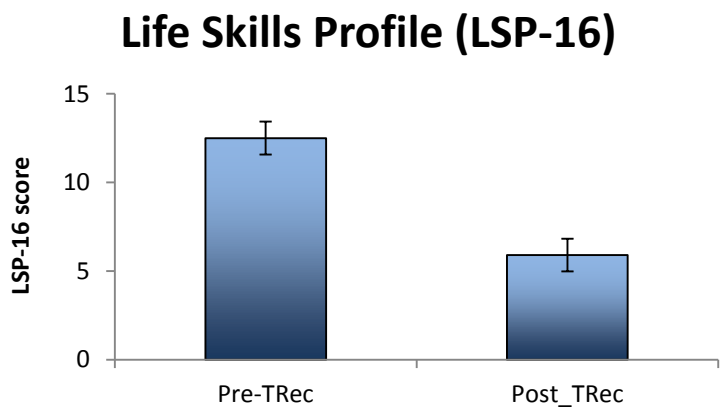

Figure 3. Mean LSP-16 at Pre- and Post-TRec
Note. Scores range from 0-48 with lower scores indicating greater functioning.

[1] Note that due to the small sample size, the findings from each parametric test were confirmed using a non-parametric equivalent method. No substantial differences between the outcomes of the parametric and non-parametric analyses were obtained. Hence, only the parametric results are reported in this report.

3.1.2 Kessler Psychological Distress Scale (K10)

The K10 was administered by the Evaluation team to evaluate the severity of the participant's psychological distress.

It was expected that the K10 would be completed by all Pre-TRec participants when they commenced and finished the program. However, as noted above, participants in the Pre-TRec group did not accept the invitation to complete the K10 at follow-up. Consequently, only baseline K10 data were available for the Pre-TRec group. Conversely, since they were not interviewed until after the program, only post- K10 data were available for the Post-TRec group.

Therefore, for the current purposes the Pre-TRec participants' K10 data were employed as a control to be compared with K10 data from the Post-TRec participants.

The K10 Pre-TRec scores were higher than the K10 Post-TRec scores. In fact, **Pre-TRec participants were approximately 11 times more likely to be categorized in the "high to very high" distress category compared to Post-TRec participants** (Odds Ratio = 11.7; 95% CI: 1.2, 119.5; see

Figure 4. Number of participants in each K10 category at Pre- and Post-TRec

). Further, a two-tailed 2x2 Fisher's exact test revealed a statistically significant difference between Pre- and Post-TRec categories (p = .03).

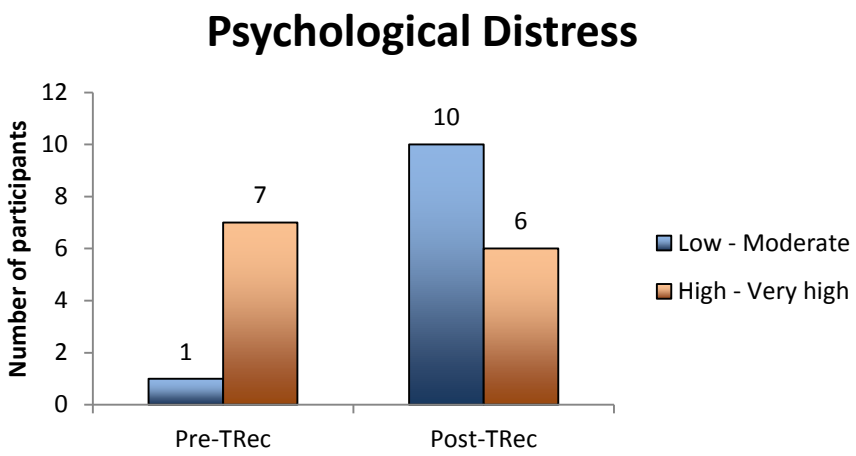

Figure 4. Number of participants in each K10 category at Pre- and Post-TRec

A two-tailed independent samples t test was conducted to compare K10 scores between the Post-TRec (post, M = 20.5, SD = 8.1) and Pre-TRec (pre, M = 30.8, SD = 8.4) groups. There was a statistically significant, large difference between the two groups (t (22) = -2.90, p = .008, Cohen's d = 1.2 (large effect)). Participants' K10 scores from the Post-TRec group were on average 10.3 points lower than scores of participants in the Pre-TRec group.

3.1.3 Personal Well-being Index (PWI)

The seven domain scores of the PWI were summed to yield an average score representing overall subjective wellbeing (and multiplied by 10 resulting in a possible 100% of subjective wellbeing). The eighth domain on spirituality or religion was not included, due to its low predictive power for the overall domain (0.4 percent of the variance).

A two-tailed independent samples t-test was conducted to compare overall subjective wellbeing between the Post-TRec group and the Pre-Trec group. **There was no statistically significant difference in wellbeing between the pre- and post-cohorts** (Cohort 1: *M*=50.8, *SD* =19.3; Cohort 2: *M* = 45.5, *SD* = 21.8; t(22) = 0.61, *p* = .550).[2]

3.1.4 Self-stigma of Depression Scale (SSDS)

Data were available to compute three subscales on the Self-stigma of Depression Scale, namely, Shame, Self-Blame, Social Inadequacy. Table 1 summarizes the descriptive statistics (*Mean*, *SD*, *Min*, *Max*) for these three subscales.

Table 1. Descriptive statistics for Self-stigma of Depression Scale subscales

	Total		**Cohort 1**		**Cohort 2**	
	M	**SD**	**M**	**SD**	**M**	**SD**
Shame	11.2	4.4	12.1	4.6	9.3	3.3
Self-Blame	9.6	2.8	9.4	2.8	9.9	3.0
Social Inadequacy	11.5	3.2	11.8	2.8	10.8	4.0

Separate two-tailed independent samples t tests were conducted to compare the Self-stigma of Depression Scale subscales scores separately between the Pre-and Post-TRec groups: **no statistically significant differences between the two cohorts were found for the three self-stigma subscales:** Shame, *t* (22) = 1.54, *p* = .139; Self-Blame, *t* (22) = -0.35, *p* = .726; and Social Inadequacy, *t* (22) = 0.77, *p* = .452.

3.1.5 Service use

In total, 18 clients provided consent for the evaluation team to access their service use data from ACT MH.

Service events were categorized into 1) *community service use* (including email and telephone contact with community mental health teams (CMHTs), contact time at CMHT offices and home visits from CMHT staff); 2) *emergency service use* (including email and telephone contact with the Crisis and Assessment Team, (CATT), and home visits by CATT), and 3) *inpatient hospital use* (e.g. at the Adult Mental Health Unit). For each service use event the amount of time in minutes was available. In order to standardize the service use for each client, the average service use per day in minutes before, during and after the TRec program was calculated.

[2] Testing each domain separately (using seven two-tailed independent samples t tests), no significant differences for a single domain were revealed.

1) Community service use

A one-way repeated-measures ANOVA was conducted to compare community service use (average minutes per day) before, during and after TRec. Mauchly's test indicated that the assumption of sphericity had been violated ($\chi^2(2) = 19.10$, $p < .001$); therefore degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\varepsilon = .59$). The results show that there were **no statistically significant differences in community service use** before ($M = 14.61$, $SD = 16.15$), during ($M = 12.05$, $SD = 5.79$) and after TRec ($M = 6.80$, $SD = 5.70$); **however, there was a decreasing trend in community service use over time** ($F(1.18, 20.04) = 3.27$, $p = .08$). Figure 5 shows the average community service use in minutes per day before, during and after the TRec program (including standard error bars). In addition, **over time the services use becomes less variable** (smaller error bars over time).

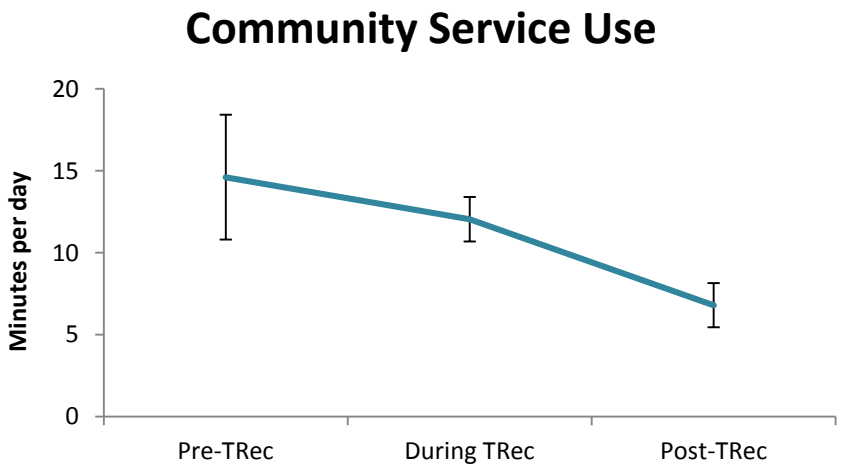

Figure 5. Community service use in minutes per day pre-, during and post- TRec

2) Emergency service use

Another one-way repeated-measures ANOVA was conducted to compare emergency service use (average minutes per day) before, during and after TRec. Again, the Mauchly's test indicated that the assumption of sphericity had been violated ($\chi^2(2) = 17.17$, $p < .001$); therefore, degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\varepsilon = .60$). The results show that **there were statistically significant differences in emergency service use over time** ($F(1.19, 19.03) = 11.88$, $p = .002$). The effect size was large ($\eta^2 = .31$). Analyses of post hoc pairwise comparisons (Bonferroni corrected) showed that **emergency service use decreased significantly from the time before TRec started** ($M = 3.03$, $SD = 2.98$), to during the TRec **program** ($M = 0.59$, $SD = 1.42$), $p = .019$; and **to the time after TRec was finished** ($M = 0.18$, $SD = 0.42$), $p = .004$. Figure 6 shows the average emergency service use in minutes per day before, during and after the TRec program (including standard error bars).

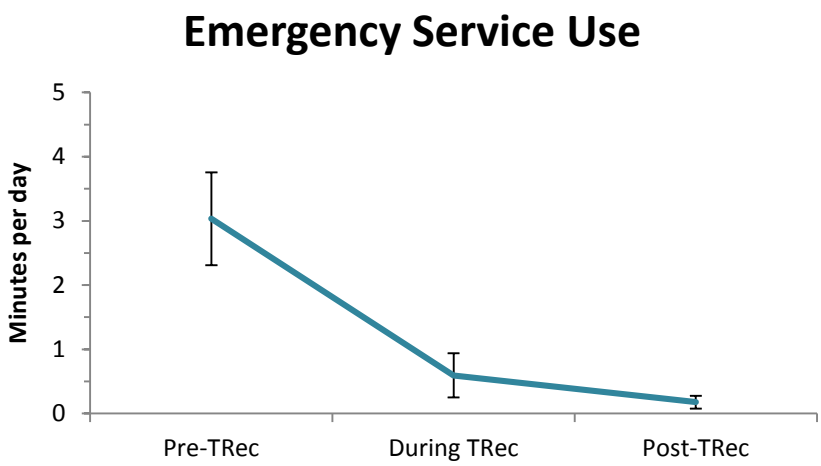

Figure 6. Emergency service use in minutes per day pre-, during and post- TRec

3) Inpatient hospital service use

A third one-way repeated-measures ANOVA was conducted to compare inpatient hospital service use (average minutes per day) before, during and after TRec. Again, the Mauchly's test indicated that the assumption of sphericity had been violated ($\chi^2(2) = 8.36$, $p = .015$), therefore; degrees of freedom were corrected using Greenhouse-Geisser estimates of sphericity ($\varepsilon = .67$). The results show that there were statistically significant differences in inpatient hospital service use over time ($F(1.33, 17.32) = 19.33$, $p < .001$). The effect size was large ($\eta^2 = .47$). Analyses of post hoc pairwise comparisons (Bonferroni corrected) **show that inpatient hospital service use decreased significantly from the time before TRec started** ($M = 334.31$, $SD = 239.20$), to during the TRec program ($M = 58.70$, $SD = 106.12$), $p = .002$; and **to the time after TRec was finished** ($M = 21.24$, $SD = 54.21$), $p = .001$.

However, there was no significant difference in emergency service use between the time the person was attending the TRec program until after TRec was finished, $p = .701$.

Figure 7 shows the average inpatient hospital service use in minutes per day before, during and after the TRec program (including standard error bars).

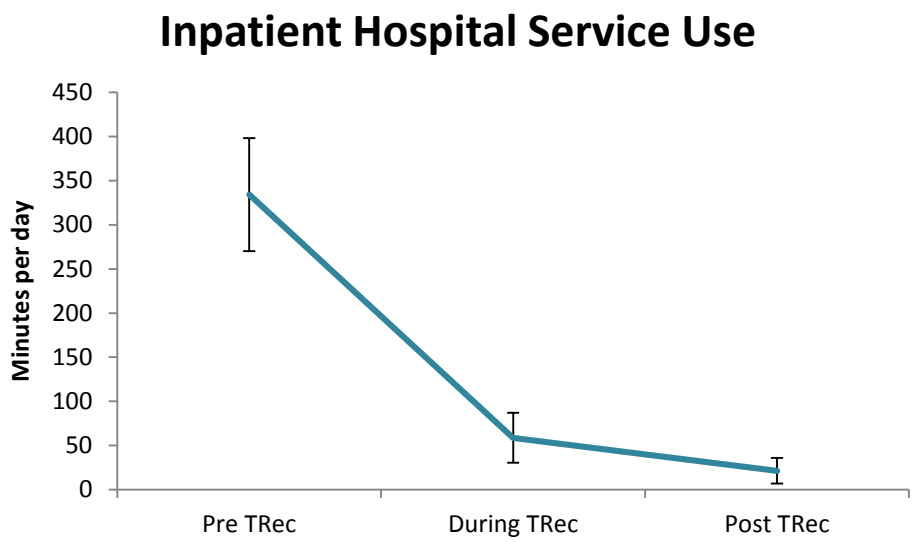

Figure 7. Inpatient hospital service use in minutes per day pre, during and post TRec

3.1.6 Summary: Effectiveness as measured by life skills, distress and service use

The findings from the LSP-16 data suggest that life skills improve over the course of the TRec program. The findings from the K10 suggest that psychological distress as rated by participants is less among those who have completed the TRec program than those who have not. However, the best test of effectiveness would be a comparison between change in outcomes scores for a group receiving TRec and a group who did not receive the program. Clearly, this is not feasible in the current context.

The results of the service use analyses showed that both emergency services (such as CATT) and inpatient hospital stays significantly decreased during TRec and remained low after the program. For community services, there was also a decreasing trend in service use over time.

3.2 Is the TRec program acceptable to participants and implementing recovery-oriented mental health practice? Qualitative data

The interviews were recorded, transcribed and analysed. The Pre-TRec group was asked a relatively limited number of open-ended interview questions. This was because the interview also contained a number of structured questions and questionnaires. It was intended to repeat these questionnaires when the participants had finished the program. However, as noted above, this group did not take up the invitation to participate in post-program interviews. Thus, the qualitative data presented below for the Pre-TRec group are relatively brief and reflect participants' experiences at the beginning of the TRec program.

The interviews for the Post-TRec program group contained a greater number of open-ended questions. These data are more detailed and are presented below.

3.2.1 Pre-TRec Group: Qualitative data

The 10 interviews with the Pre-TRec participants were analysed using qualitative thematic analysis.

1) Pre-TRec Group: Referral to TRec and reasons for participating

Participants reported that they had been referred to TRec by hospital staff (e.g. "*doctor or psychologist at the hospital*", "*occupational therapist*") and mental health teams (e.g. "*Belconnen mental health*", "*mental health ACT*", "*case manager*").

Participants' reasons for accepting the referral to TRec included their mental health (e.g. "*severe anxiety*", "*diagnosed with schizophrenia*", "*because I want to get well*") and the need for support (e.g. "*need more support*", "*trying to find as much support so I don't fail*").

2) Pre-TRec Group: Participants' goals

Seven participants (70%) highlighted personal goals they hoped to achieve by participating in the TRec program. These goals were related to going "*back to a normal life*" (e.g. "*build up basic structures*", "*getting back to work*", "*stay out of hospital*") and others were related to personal development (e.g. "*greater sense of personal confidence and ability*", "*get back some balance*").

Some participants indicated (30%, n = 3) that they had not developed any goals yet.

3) Pre-TRec Group: Areas of life for which participants would like to have support

Participants were shown a list of life areas and asked to nominate the areas for which they would like some assistance. The life area most commonly endorsed in this question was "*managing stress"* (90%, n = 10), followed by "*learning more about mental health recovery"* (80%, n = 10), "*problem solving"* (77.8%, n = 9), "*forming and maintaining relationships with family, friends and others"* (75%, n = 8), and "*decision making and goal setting"* (70%, n = 10). The full list of life areas is shown in Figure 8. The least endorsed areas were "finding a job" and "managing drug and/or alcohol issues". (Note that participants were not included in the analysis where they indicated that areas were not applicable to them).

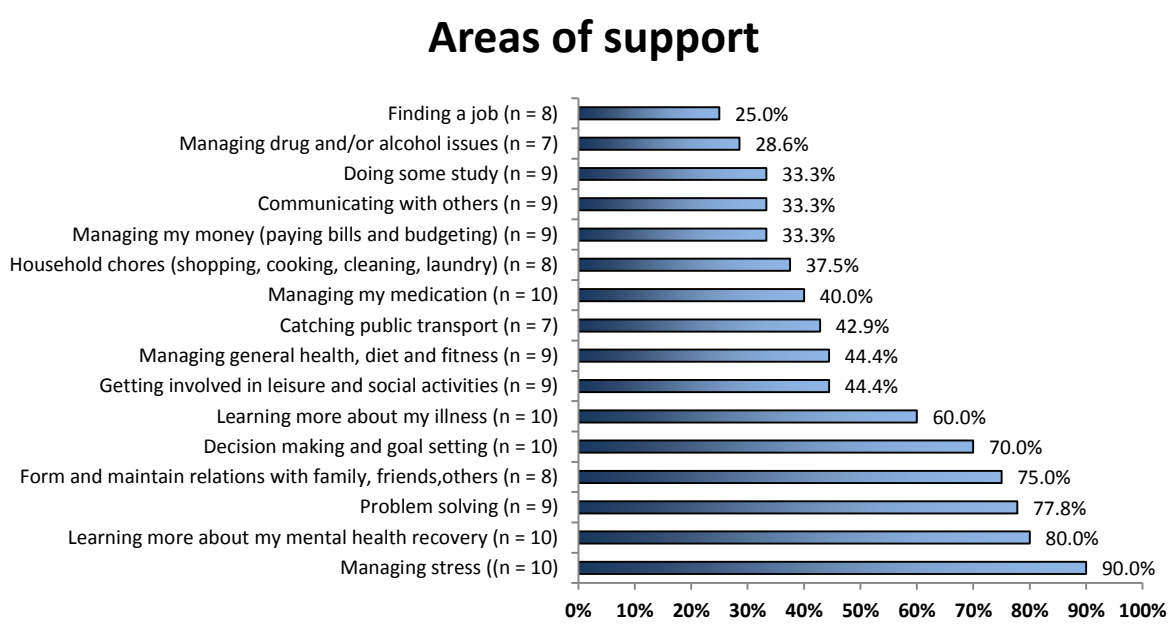

Figure 8. Areas of life in which participants would like support

3.2.2 Post-TRec Group: Qualitative data

Eighteen valid interviews were obtained from the Post-TRec group (n = 20). They were analysed using qualitative thematic analysis.

1) Post-TRec Group: Overall Satisfaction

Overall, participants regarded the TRec program very positively (88.9%, n = 16) and used descriptors such as "*good"*, "*helpful*", "*personal*", and "*supportive*".

Figure 9 displays the frequencies of particular words that were used to describe positive aspects of the TRec program. These frequencies were generated through the N-Vivo software program from the qualitative interview data. The size of the word reflects its frequency (e.g., "*good program*" was the most frequent description of TRec, followed by "*helped*" and "*helpful*").

Figure 9. Word frequencies regarding positive aspects of the TRec program

With respect to the thematic analysis, participants most frequently (n = 9) referred to the individualised relationship between participants and TRec workers (e.g. "*Great to be assigned one particular worker*"). Several participants (n = 7) emphasized the importance of having somebody to talk to who listened (e.g., "*Having someone to talk*", "*patient listening, an understanding ear*"); and that the TRec workers were able to motivate participants to be more active (e.g. "*Helped motivate me to get out of the house*"). Numerous participants highlighted the support provided by TRec in general (e.g. "s*upport at a difficult time*"), and with specific appointments (e.g. "*help with outside situations and appointments*"). Other positive comments included the following:

> "*Somehow got out of me what I wanted to accomplish in the next year or two and helped me to achieve it. They believed in me.*"
>
> "*Made me feel like a human being again*. "
>
> "*My impression as a consumer was it was a really cost effective way to meet my needs because I know she was seeing a number of other people and we spent up to about 2 hours a*

week together, twice a week… So it seemed to me that for the amount of help I received … it was a really cost effective way of providing that help."

Two participants (11.1%) were not satisfied with the support offered by TRec (e.g. "*Nothing stood out. I didn't find the talking to be useful"; "I had to ask them to stop calling me like every night and that was bit intrusive.*"). One of these participants reported that they had not been engaged or helped by participating in TRec.

> *"TRec didn't help me. I've had no success with understanding my mental illness I don't understand it at all, the illness. So no one has been of any use to me… I didn't feel engaged by TRec. "*Post-TRec Group: Recommending TRec to other people

Almost all participants would recommend TRec to a friend who was in a situation similar to the one the participants were in just before starting TRec (94.4%, n = 17):

> *"It was very flexible, it was personal, it was confidential. And it was consistent, it was reliable and also it helped give me structure."*

2) Post-TRec Group: What would have happened without the TRec program?

When asked what would have happened if TRec had not been available for them at the time they began the program, 13 participants (72.2%) believed that they would have experienced serious negative events.

Four participants reported potential suicide *(*e.g. *"Would have killed myself"*); two participants reported potential admission to hospital *(*e.g. *"I would have gone into hospital*"); and two participants reported potential drug abuse (e.g. "*I might have been still using drugs*"). The rest of the participants (n = 7) indicated that without the support of TRec it would have been "*stressful"* and "*difficult"*. Figure 10 displays the word frequencies for potential outcomes without the TRec program as generated through the N-Vivo program from the qualitative interview data.

Figure 10. Word frequencies for potential outcomes if TRec had not been available

3) Post-TRec Group: Satisfaction with TRec components

Participants were asked about their satisfaction with particular components of the TRec service. Response categories of "*satisfied*" and "*very satisfied*" were combined in this analysis. The majority of participants were *satisfied* or *very satisfied* with the various TRec components and all but one component was rated in this way by at least 80% of the participants. See Figure 11 for details. (Note that participants who reported that TRec components were not applicable were not included in the calculation.)

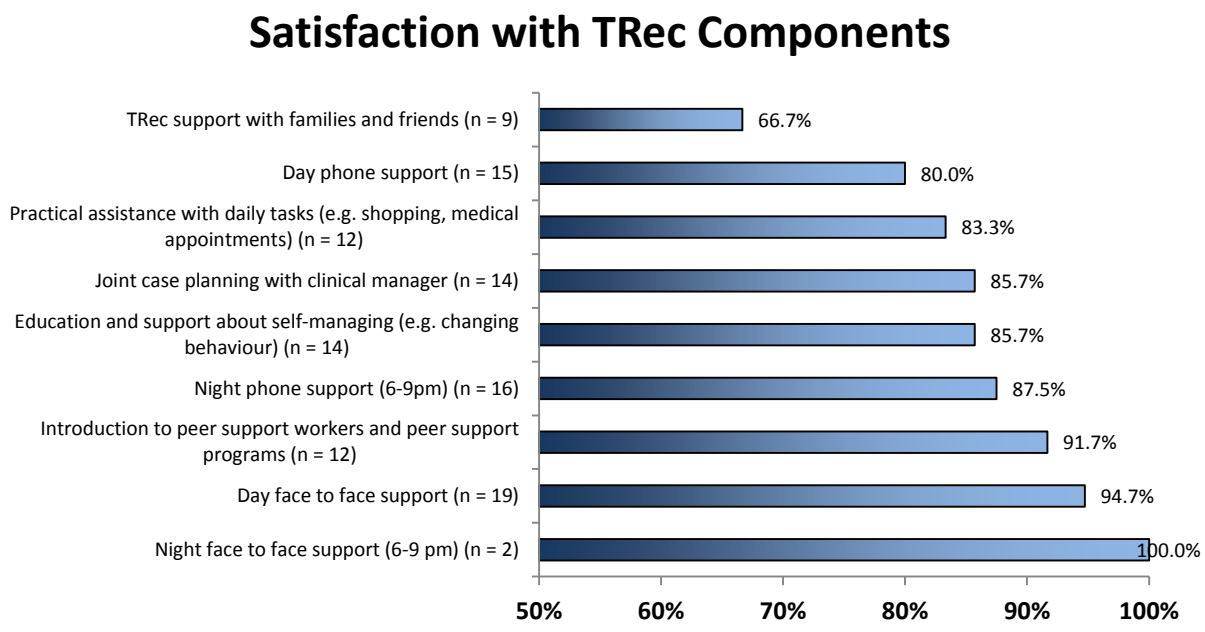

Figure 11. Satisfaction with TRec components

Participants were also asked how satisfied they were with the help and support provided by TRec in various aspects of their lives. Figure 12 displays the frequencies of the combined categories *satisfied* and *very satisfied*. All areas were rated positively by more than 80% of the participants who responded to each area. (Note that participants who reported that particular areas were not applicable were not included in the calculation.)

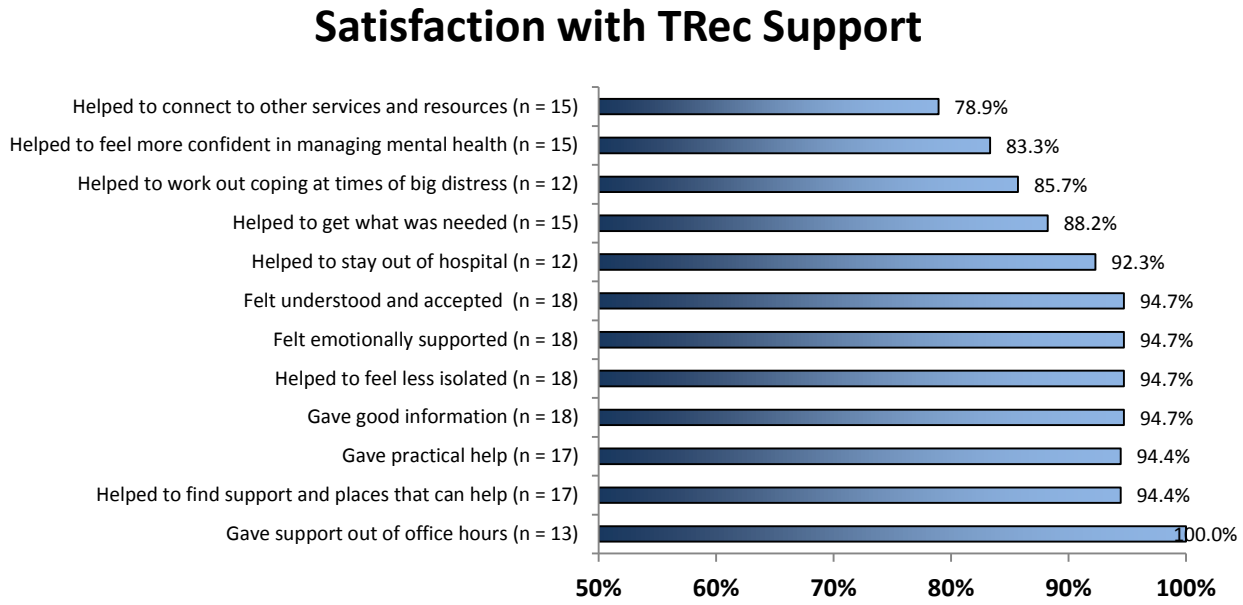

Figure 12. Satisfaction with TRec support for various areas of life

4) Post-TRec Group: Working on Recovery Goals

Twelve participants reported working on personal goals during the course of the TRec program. Six of these participants specified goals that they had worked on with support from TRec. Goals included developing a better structure to their lives (e.g. "*just to have some sort of stability in my life*"; "*being able to take care of myself such as with cooking and shopping*"); and being more active (e.g. *"try and participate more, be more socially active"*).

Some participants indicated specific ways in which TRec helped them to achieve their personal goals (e.g. *"the regular meetings were a good way of keeping on track, helped to develop a routine"*).

Two participants indicated that TRec had not helped them to achieve goals (e.g. *"there was a lot of talk about it, but no real action"*).

5) Post-TRec Group: Perceived differences between TRec and MHACT services

Half of the participants (55.5%, n = 10) commented on the depth and quality of support of TRec compared to other services. Some participants perceived TRec workers as having more time and being more flexible (e.g. *"they (MHACT services) are overloaded at work … you're definitely another number, but TRec … makes sure my case manager is here and I keep my doctors' appointments… I'm seeing my case manager a lot more now than I used to."*), whereas others highlighted the quality of support (e.g. *"they (TRec) looked at big pictures."*). Several participants (44.4%, n = 8) emphasized the personal contact with TRec workers (e.g. *"the personalised attention helps you"*) while others (27.8%, n = 5) emphasized the practical focus of TRec (e.g. *"it was very practical"*).

6) Post-TRec Group: Suggestions for program improvement

Nine participants (50%) said they could not think of any improvements that could be made to the TRec program.

However, five participants (27.8%) suggested that increased staff and resources would improve the service (e.g. *"employ more staff"; "24 hour service line, "more cars and more employees so the practise was expanded to the entire state of the ACT").* Others suggested that the process of exiting the program might be improved (e.g. *"it does sort of end abruptly"; "follow up participants after a month or 6 weeks"*).

7) Post-TRec Group: Other quotes from participants

The following are some responses from participants when they were asked if they wished to make any further comments about the program:

> *"Just that I'm very thankful and grateful that I got those 3 months in my recovery process and that it's been a nice journey."*
>
> *"I regard them highly. I think they are great at what they do."*
>
> *"They are really good. I was quite surprised there is a service like that when they told me."*
>
> *"Just some awards maybe would be good, some recognition for the workers."*

3.2.3 Summary: Satisfaction and Recovery Orientation

The findings from the qualitative data analyses (Post-TRec cohort) suggested that participants were generally satisfied with the program and its components. Almost all participants would recommend TRec to a friend who was in a situation similar to the one the participants were in just before starting TRec. The majority of participants were satisfied with the various TRec components such as day, night and face to face phone support and practical assistance with daily tasks.

3.3 Feedback from other stakeholders

Feedback from three other groups of stakeholders was collected: TRec workers, ACT MH staff and carers.

3.3.1 Feedback from TRec workers

Eight TRec workers provided feedback about the program by completing the Recovery Self-Assessment (RSA) scale. This scale is designed to measure the degree to which a particular program implements recovery-oriented practices.

The RSA contains 36 items comprising five subscales that measure the following domains essential to recovery: *Life Goals* (how the system encourages clients to pursue individual goals and interests), *Involvement* (how the system allows clients to become involved in recovery-oriented programs), *Diversity of Treatment Options* (how the system offers a range of treatment options and styles), *Choice* (how the system takes into account client preferences and choices during the recovery process), *Individually-Tailored Services* (how the system helps clients tailor their treatment program to their individual needs). All items are rated using the same 5-point Likert scale that ranges from

strongly disagree (1) to strongly agree (5). The original evaluation design included an RSA measure to provide feedback from the Pre-TRec group on the attributes of the TReC program (after they completed the TRec program). However, as noted above, this group did not provide Post-TRec data. Thus, it was not possible to compare the perspectives of TRec workers and clients as to whether the program implements recovery-oriented practices.

TRec workers' responses on the RSA indicated that the program implements recovery-oriented practices. Workers agreed that the TRec program encourages clients to pursue individual goals and interests (*M* = 4.6, *SD* = 0.4), offers a range of treatment options and styles (*M* = 4.5, *SD* = 0.4), takes into account client preferences and choices during the recovery process (*M* = 4.5, *SD* = 0.5), and helps clients tailor their treatment program to their individual needs (*M* = 4.5, *SD* = 0.3). There was also agreement that the program allowed clients to become involved in recovery-oriented programs (*M* = 4.0, *SD* = 0.6). See Figure 13 for details. Strongest agreement from TRec workers included the following statements (all workers strongly agreed):

Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program.

Staff believe in the ability of program participants to recover.

Staff regularly ask program participants about their interests and the things they would like to do in the community.

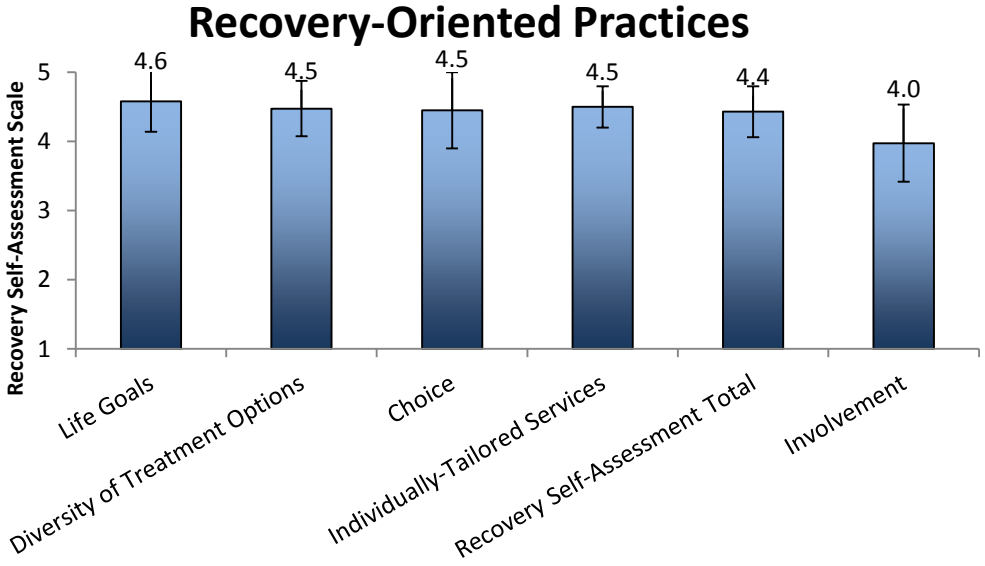

Figure 13. Feedback from TRec workers (means and standard error bars) using the Recovery Self-Assessment scale (RSA).

3.3.2 Feedback from ACT Mental Health staff

Feedback was received from 17 ACT MH staff. Almost all of the respondents had referred clients to TRec (94.1%, n = 16), and all intended to refer clients to TRec in the future. When asked how satisfied they were with the TRec program, 88.2% (n = 15) were very satisfied or satisfied with the program.

In addition, ACT MH staff responded to some open-ended questions.

When ACT MH staff were asked to identify the most useful aspects of TRec, they highlighted the intensive support provided to assist clients in the transition from hospital to community, the support provided after hours and on weekends, the ongoing monitoring, medication reminders, the time TRec was available for each client, and the good collaboration between TRec workers and ACT MH staff.

When asked to nominate the least useful aspects of TRec, the staff mentioned the lengthy referral form and the limited timeframe of the program (12 weeks).

When asked to suggest improvements to the TRec program, ACT MH Staff suggested more regular communication with ACT MH case workers. Several respondents recommended that the timeframe of the TRec program be extended and the numbers of TRec workers be increased.

3.3.3 Feedback from carers

Only one carer returned a feedback form. Unfortunately, results from a single person cannot be presented here, due to confidentiality issues.

4 Conclusion

This evaluation study investigated whether the TRec program was effective, acceptable and implementing recovery-oriented practices. It also sought suggestions for program improvement.

Some of the planned evaluation data could not be collected and no control group was included in the study. Nevertheless, the available data on mental health outcomes and service use is promising. Further, the findings indicate that the program is acceptable to consumers and consistent with recovery-oriented mental health practice.

This evaluation addressed the following specific questions as listed in the Introduction to this report:

4.1 Is the TRec program effective?

Participation in the TRec program was associated with **promising *health and service* outcomes** including:

a) lower psychological distress and higher functioning in life skills that are indicative of more successful community functioning (section 3.1)
b) reduced relapse and (re-) admission to hospital. This is indicated by quantitative data showing decreased use of emergency and hospital services during and after participation in TRec (section 3.1.5). This is supported by the qualitative data, as most participants indicated that they would have experienced negative consequences if TRec had not been available to them. These consequences included suicide, hospitalisation, substance use and high levels of stress (Section 3.2.2. Participants also reported high levels of satisfaction with the help they had received from TRec to "*stay out of hospital*" and to "*work out how to cope at times of big distress*" (3.2.2).

4.2 The TRec program support

The Trec program provided participants with experiences that might be expected to *support recovery* by providing:

a) **The right kind of support at times that participants require it:**

   This was demonstrated by the high levels of participant satisfaction with TRec services including support available during office hours as well as outside these times and provided by telephone as well as face to face; the provision of practical help and assistance with daily tasks (Section 3.2.2).

   MH ACT staff also indicated high levels of satisfaction with the service and highlighted the intensive and flexible nature of the support provided as particularly useful (Section 3.4.2).

b) **Support to increase awareness of and access to community resources and support networks:**

Participants reported high levels of satisfaction with the support they received to assist them to feel less isolated and to increase access to community resources and support. This included peer support programs, other services and resources and liaison with MH ACT case managers as well as help with outside appointments (Section 3.2.2).

Feedback from the MH ACT workers also referred to good collaborative relationships with the TRec workers (Section 3.4.2)

c) **Support and education to increase their knowledge, skills and confidence in managing future crises and to develop personal resources to enhance their mental and emotional well-being:**
Participants reported high levels of satisfaction with support they received from TRec to help them feel more confident in managing their mental health and with the information and education they received about self-management (Section 3.2.24).

d) **Delivering the service in a manner that is acceptable to stakeholders and implements recovery-oriented practices:**

Most participants rated the TRec program as highly acceptable. Almost all indicated that they would recommend the service to others (Section 3.2.2). MH ACT workers also indicated that the program was acceptable and highlighted the flexible nature of the TRec service, the good collaboration between TRec and MH ACT as well as the capacity of TRec workers to spend time with participants as needed (section 0.2).

The evidence from staff suggests that the Trec program is implementing recovery-based practices. In particular, the RSA ratings provided by TRec workers suggests that the service provides individualised, optimistic and person-centred support (Section 3.4.1).

Although it wasn't possible to collect RSA data from participants, relevant data was obtained from their interview responses. The latter highlighted the individualised, personalised support provided by TRec workers and generally, participants felt emotionally supported, accepted and understood (Sections 3.2.2). Participants also cited individualised goals for their work in the program (Section 3.2.2).

4.3 Potential areas for improvement

At the beginning of the evaluation, it was agreed that any suggestions for improvement that arose would be incorporated into the program where possible and then the improved program would also be evaluated. This was ultimately not possible, but the feedback we obtained from the Post-Trec group and MH ACT staff (Sections 3.2.2 and 3.4.2) was provided by the researchers to the TRec team.

Key suggestions for improvement were to:

- extend the time frame of the program for people who needed a longer period of support and explore a graduated exit, with one or more follow-up appointments.
- seek to increase the resources allocated to the program so it can be delivered to more people.
- work with MH ACT to build on the collaborative relationship already achieved, further develop communication between the services, establish whether referrals could be streamlined and the referral form simplified.
- explore whether some participants require additional support in their relationships with friends and family - this element of TRec's service was rated as less satisfactory than other service elements.

While it did not directly arise from this evaluation, TRec has also indicated that it wishes to establish an ongoing evaluation process to inform workers and participants of progress as they work through the program. This positive development is consistent with recovery-oriented principles and will provide an ongoing quality assurance mechanism that will enable iterative improvement in the program if and as indicated.

5 References

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[5] Leamy, M., Bird, V., Boutillier, C. L., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *The British Journal of Psychiatry*; 199, 445-452.

6 Appendix

6.1 Appendix A. Scales and measures for which data is not reported

It was not possible to perform some comparisons or report data from some measures employed in the evaluation due to missing data. The Table 2 provides an overview of comparisons and measures that are not included in the report.

Table 2. Scales and Measures

Name of scale/measure	
Comparisons for which partial data was obtained and presented in report	
Personal Well-being Index (PWI) Kessler 10 (K-10) Recovery Self-Assessment (RSA) consumer, family member and provider versions	It was planned to compare participants' PWI and K10 scores before and after they had participated in TRec. It was not possible to collect follow-up data for those participants entering Trec at the time of the evaluation. It was possible to compare the scores of people who had already completed Trec at the time of the evaluation with the scores of people who were just entering Trec during the evaluation (Section 3.1.3). It was planned to compare ratings on the RSA made by TRec staff with ratings from family/ carer respondents and with post-program ratings from participants who completed the program during the evaluation period. Data was available from TRec workers only and this is presented in the report (3.4.1)
Measures not presented in the report due to missing data	
Self-Identified Stages of Recovery (SISR), Brief Resilient and Coping Scale (BRCS) INSPIRE – relationships subscale Recovery Assessment Scale (RAS	There were three groups of participants. Participants who had completed TRec at the time the evaluation began are referred to as the Post-TRec group in the report. The other two participant groups entered the program during the evaluation. In the report these are referred to as the Pre-TRec and Improvement groups. It was planned to compare these participants' scores on these scales at program entry and exit. It was not possible to make these comparisons due to missing data
Burden Assessment Scale (BAS) Depression and Anxiety Distress Scale (DASS)	It was not possible to present Family/Carer data as only one valid response was received.